



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor  
RICHARD M. ARMSTRONG – Director

DEBRA RANSOM, R.N., R.H.I.T., Chief  
BUREAU OF FACILITY STANDARDS  
3232 Elder Street  
P.O. Box 83720  
Boise, ID 83720-0036  
PHONE 208-334-6626  
FAX 208-364-1888

March 9, 2007

Richard Nebeker, Administrator  
One Source HHC, LLC  
3455 E 17<sup>th</sup> St Suite 201  
Ammon, ID 83406

RE: One Source HHC

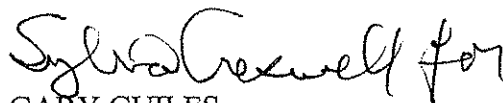
Dear Mr. Nebeker:


This is to advise you of the findings of the initial Medicare/licensure survey for One Source HHC, LLC, which was concluded on February 14, 2007.

Enclosed is your copy of a Statement of Deficiencies/Plan of Correction, form CMS-2567, and the State survey report which state that no deficiencies were noted at the time of the survey. Also, enclosed is a full Home Health Agency license effective through December 31, 2007.

Thank you for the courtesies extended to us during our visit. If you have any questions, please write or call this office at 334-6626.

Sincerely,

  
GARY GUILLES  
Health Facility Surveyor  
Non-Long Term Care

  
SYLVIA CRESWELL  
Supervisor  
Non-Long Term Care

GG/jd

Enclosures

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

Printed: 02/28/2007  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>OSHHHC</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>02/14/2007</b>
NAME OF PROVIDER OR SUPPLIER <b>ONESOURCE HHC, LLC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3455 E. 17TH STREET. SUITE 201 AMMON, ID 83406</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
G 000	<p><b>INITIAL COMMENTS</b></p> <p>No deficiencies were cited during the initial Medicare certification survey of your Home Health Agency. Onesource HHC is in compliance with the requirements of 42 CFR Part 484, Conditions of Participation for Home Health Agencies. The surveyors conducting the initial Medicare certification survey were:</p> <p>Gary Guiles, R.N., H.F.S., Team Leader Penny Salow, R.N., H.F.S. Rae Jean McPhillips, R.N., H.F.S.</p>	G 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>OSHHHC</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>02/14/2007</b>
NAME OF PROVIDER OR SUPPLIER <b>ONESOURCE HHC, LLC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3455 E. 17TH STREET, SUITE 201 AMMON, ID 83406</b>		
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N 000	<p>16.03.07 INITIAL COMMENTS</p> <p>No deficiencies were cited during the initial State licensure survey of your Home Health Agency. Onesource HHC is in compliance with the requirements of IDAPA 16.03.07, Rules for Home Health Agencies. The surveyors conducting the initial State licensure survey were:</p> <p>Gary Guiles, R.N., H.F.S., Team Leader Penny Salow, R.N., H.F.S. Rae Jean McPhillips, R.N., H.F.S.</p>	N 000			

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TITLE

(X6) DATE